



Vermont System of Care Report 2021

COVID-19 Edition

Submitted by State Interagency Team (SIT)

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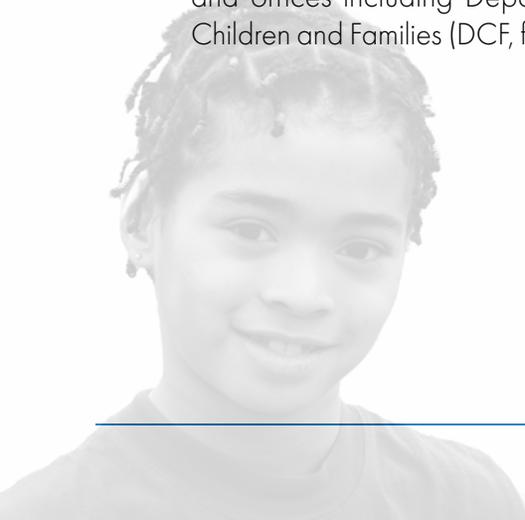
This system of care report is in response to the Act 264 statutory requirement as outlined in 33 VSA § 4302 which requires the State Interagency Team (SIT) to submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. The system of care plan shall identify the characteristics and number of children and adolescents with a severe emotional disturbance in need of services, describe the educational, residential, mental health or other services needed, describe the programs and resources currently available, recommend a plan to meet the needs of such children and adolescents, and recommend priorities for the continuation or development of programs and resources.

In 2005, an interagency agreement was established which expanded the scope of the statute in the following way: This interagency agreement outlines the provision of services to students who are eligible for both special education and services provided by AHS and its member departments and offices including Department of Health (VDH), Department for Children and Families (DCF, formerly Social and Rehabilitation Services),

Department of Mental Health (DMH), Department of Disabilities, Aging and Independent Living (DAIL), Department of Corrections (DOC), Office of Vermont Health Access (now DVHA-Department of Vermont Health Access), and the Department of Education (now AOE-Agency of Education). It is intended that the agreement will provide guidance to human services staff and school personnel in the coordination and provision of services for students with disabilities.

The priorities outlined in this report are the result of ongoing feedback and dialogue from a number of stakeholders including the 12 Local Interagency Teams (LIT), the Act 264 Advisory Board Annual System of Care recommendations, data analysis from the departments of the Agency of Human Services and the Agency of Education and discussion at monthly State Interagency Team meetings. Feedback and input about the Children's System of Care comes in a variety of manners—through face-to-face meetings, annual LIT surveys, electronic communications and phone calls.

This year's report focuses on both the challenges and innovative work accomplished by the dedicated individuals who have continued to support children, youth and families during the COVID pandemic.



- 1 Utilize the Residential Analysis Report to increase the number of children, youth and families served in community settings by investing in community-based supports and focusing on mobile response efforts in Vermont.
- 2 Continue supporting funding structures that are coordinated and streamlined to the highest extent possible across AHS departments, moving away from fee-for-service funding and toward value-based payments.
- 3 Support statewide services being streamlined and coordinated during and after the pandemic.

Every year Local Interagency Teams respond to an annual survey the Act 264 Board sends out to gather input from across the state. The following are some of the responses to questions about what challenges teams were experiencing and what is working well.

Challenges

- Increase in homelessness
- Food insecurity of families
- Childcare needed
- Difficulty getting respite services
- Concern for children's safety given the decrease with in-person contacts
- Families not having access to the internet
- More need for micro residencies
- Concern about the long-term impact of COVID on the mental health of children, youth and families
- Increase in domestic violence
- Need for more alternative school placements

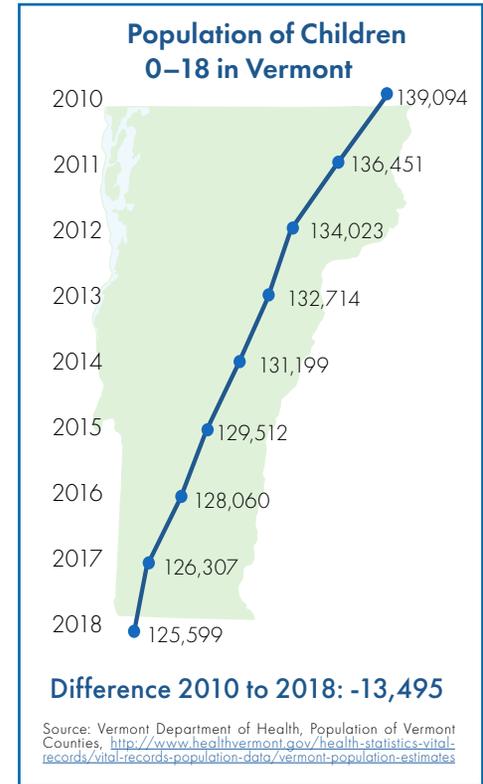
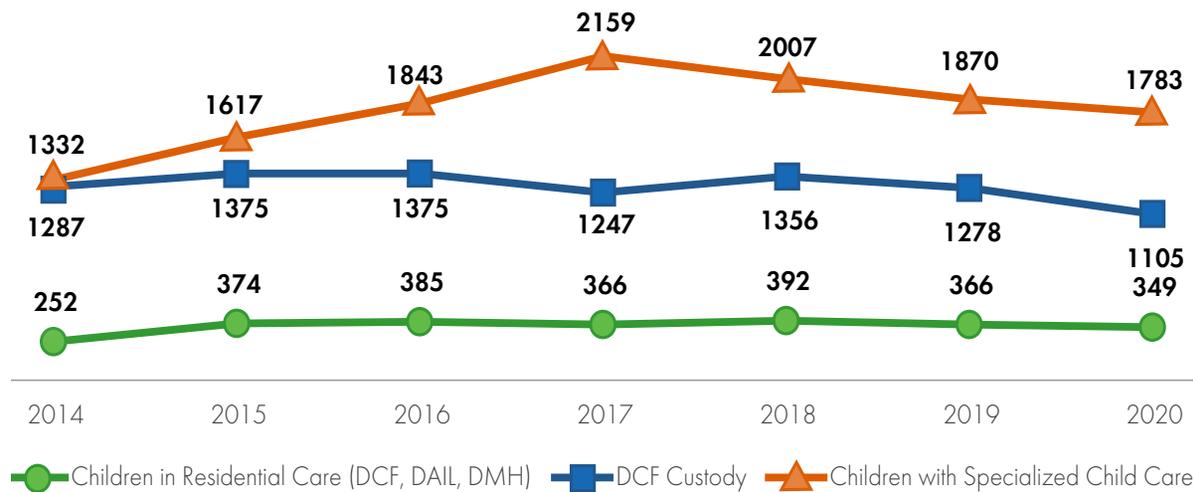
What is working well?

- More connection with parents through virtual meetings
- Additional virtual groups for children and families, parenting groups
- More partnering and networking across agencies
- It is important to maintain our positive culture and be patient with each other—we are all doing the best we can at this time.
- Food deliveries for families
- Helped to deliver food, cleaning supplies, PPE, and entertainment/books to kids.
- Strong parent representative on LIT
- Facebook groups were created locally to provide support, encouragement and information regarding local resources

- 1** Due to COVID, the annual Local Interagency Team gathering was not held this year. However, several virtual “LIT Connections” meetings are scheduled for December 2020, January 2021 and February 2021. These virtual meetings will create the opportunity for statewide sharing of information, resources and ideas.
- 2** In 2019, an interagency workgroup created a formal proposal was created outlining the need for [MRSS in Vermont](#). Due to the pandemic, funds were not realized for FY21, however, as a system we will continue to advocate for the resources needed to make the proposal a reality.
- 3** Progress continues on payment reform efforts. On January 1, 2019 DMH and DVHA moved all designated agencies out of fee-for-service funding and into case rates for mental health services. This alternative payment model has assisted in creating flexibility and fiscal stability during COVID. DAIL is currently undergoing payment reform efforts as well.
- 4** An Interagency team made up of staff leadership from DMH, DAIL and DCF-Family Services supported an independent contractor, Public Consulting Group, in a months-long analysis of Vermont’s children’s residential system of care to determine the steps Vermont can take to increase community-based supports and services; increase the ability of families to care for their children while they receive the necessary therapeutic treatment; and provide necessary treatment within family like settings, thus decreasing the need to receive that treatment within a residential setting. The full report will be released soon.
- 5** DMH and ADAP jointly applied for a Substance Abuse and Mental Health Services Administration (SAMHSA) grant with only seven business days to complete the grant application; we were notified just four business days later that Vermont received the maximum of \$2 Million. This grant is contributing to our system for provision of crisis intervention services, mental and substance use disorder treatment, and other related recovery supports for children and adults impacted by the COVID-19 pandemic. It is also increasing access to care for healthcare workers with mental health needs.
- 6** The departments of the SIT provided \$22,500 to the Vermont Federation of Families for Children’s Mental Health to support parent representation for the Act 264 process. This continues the financial support provided to VFFCMH over the last several years by SIT departments in its commitment to parent voice.
- 7** DMH and DAIL-DDSD has been meeting to increase collaboration and partnership across the departments with the goal being to streamline and coordinate for youth who have both mental health and developmental needs. There have been many situations where this joint problem-solving has enabled local teams and families to receive support without the need for higher level consultation.

There is no question there is a clear decline in the population of children 0-18 in Vermont (see sidebar), however, there is still a significant need for supports and services by families facing poverty, struggling with opiate addiction, limited employment opportunities, and the impacts Adverse Family Experiences have on children. As well, the impact of the COVID pandemic is expected to be felt for years to come.

Figure 1: Acuity of Need



COVID Fact: Increase in Children Living in Hotels

When the eligibility requirements for temporary housing expanded in March to help Vermonters stay safe during COVID, the numbers being housed in hotels increased sharply.

As of December 18, 2020, the number of children in hotels across Vermont was **394**.

Source: <https://dcf.vermont.gov/sites/dcf/files/ESD/Report/GA-AR-2020.pdf>

The Vermont Department of Mental Health (DMH) had been reporting data to SAMHSA on the number of children served through the Designated Agency and Specialized Service Agencies (DA/SSA) system with severe emotional disturbance (SED), using the federal definition of SED identified by Global Assessment of Functioning (GAF) scores 50 and under. However, the DSM-5 removed the GAF. Since provider agencies are expected to comply with the most current version of the DSM, they are no longer using GAF scores. Therefore, until a different tool to measure functioning or a different marker of SED is determined, trend analysis was used to determine SED numbers beginning in 2016.¹ Over the last decade, Vermont has held steady with nearly 20% of children identified as SED. In 2020, we are too far out from the original data points when GAF was collected to continue to use trend analysis effectively. When looking at children receiving services through the DA/SSA system, 8,338 children ages 0-17 had a mental health diagnosis that would qualify for SED; that represents 82% of the children served by the DA/SSAs. However, this does not take into consideration the additional requirement for a scale to determine functional impairment across settings and over time in order to determine if SED criteria are fully met. The Child and Adolescent Needs and Strengths (CANS) may be a viable option for this, but such data is not yet available at the state level.

Looking to national sources, the 2018-2019 National Survey of Children's Health shows that 26.9% of Vermont children (ages 3-17) were reported to have a "mental, emotional, developmental or behavioral problem".² Nationally, Vermont is ranked #1 for "lower prevalence of mental illness and higher rates of access to care" for youth; and #3 for "Youth with Severe [Major Depressive Episode] MDE who Received Some Consistent Treatment".³ In the same national review, Vermont is also ranked #1 for students identified with Emotional Disturbance for an Individualized Education Program.

Intervening early is critical, given that half of all lifetime cases of mental illness begin by age 14 and three-fourths by age 24. Research has shown that early identification and treatment improves outcomes. For example, early interventions conducted by comprehensive school-based mental health and substance treatment systems have been associated with enhanced academic performance, decreased need for special education, fewer disciplinary encounters, increased engagement with school, and elevated rates of graduation.⁴

In 1992, Vermont started Success Beyond Six (SB6), an Agency of Human Services funding mechanism which allows school districts to use Medicaid match to support mental health services in the schools. Under the Medicaid-supported formula, federal dollars cover about 54% of the costs for providing mental health services in the schools with local school districts paying about 46%. The mental health services provided through the designated agencies in the schools have become more varied and individualized based on the identified needs of the students. The collaboration of Local Education Agencies and Designated Mental Health Agencies has created opportunities for a spectrum of services including school-wide mental health consultation, prevention and early intervention all the way to intensive individualized services. In the 2017-2018 school year, Success Beyond Six helped fund 585 full time equivalent behavioral interventionists, as well as 175 School Based Clinicians and 25 Board Certified Behavioral Interventionists with about \$69 million in Medicaid and local dollars supporting the program. In the 2019-2020 school year, 3,656 students were served through the SB6 school mental health services statewide. This represents a 13% increase compared to the prior school year as well as the prior 10 years.

For additional information about SB6, please refer to the legislative report: [Review of Success Beyond Six: School Mental Health Services Act 72 \(2019\), Section E.314.1. January 15, 2020](#)

¹ Analysis based on Monthly Service Report data submitted to the VT Department of Mental Health by the designated agencies. Includes youth aged 9 to 17 with a primary program assignment of Children's Programs

² 2018-2019 National Survey of Children's Health, Data Resource Center for Child & Adolescent Health, <https://www.childhealthdata.org/browse/survey/results?q=7981&r=47>

³ Mental Health America, Youth 2021 Data <https://www.mhanational.org/issues/2021/mental-health-america-youth-data>

⁴ SAMHSA Bulletin, July 1, 2019, guidance to states and school systems on addressing mental health and substance use issues in schools, <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB20190701.pdf>

There is a great deal of information those working in the system of care rely upon to help inform us about what children, youth and families are experiencing and what needs exist. Two of those are, Adverse Family Experiences⁵ and Adverse Childhood Experiences⁶ which are phrases used to describe types of abuse, neglect, and traumatic experiences occurring to individuals during their childhood and within their families. We care about this information because research has shown a relationship between adverse childhood experiences and reduced health and well-being later in life. When children do experience trauma, understanding the impact of ACEs can lead to more trauma-informed interventions that help to

mitigate negative outcomes. Learn why [protective factors](#) are so important.

As well, we rely on the [Youth Risk Behavior Survey](#) (YRBS) which has been administered every other year, since 1993. The Vermont Department of Health and the Agency of Education sponsor the survey and it is supported by many partners across the state who work to achieve positive outcomes for all youth in Vermont. The YRBS was developed by the [Centers for Disease Control and Prevention](#) in 1990 to monitor priority health risk behaviors that contribute to the leading causes of death, disease, injury and social problems among youth. These behaviors, often established during childhood and early adolescence, include:

- Behaviors that contribute to unintentional injuries and violence
- Physical activity
- Nutrition
- Weight status
- Tobacco use
- Alcohol and other drug use
- Sexual behaviors

There will be more ACE, AFE and YRBS data to report in upcoming System of Care Reports.

⁵ United States Census Bureau. (2016-2018). National Survey of Children's Health. Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

⁶ Felitti, V.J., et al., Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*, 1998. 14(4): p. 245-58.

To organize information for this report, SIT looked at several data factors all with the goal to better understand the level of need that exists and current challenges arising for children and families. Designated Agencies resource LITs with children’s mental health staff (DAs do not receive additional financial resources to support this work) and they do

not have a consistent way to track CSPs in their electronic health records. LIT coordinators estimate the number of CSPs that occur and believe it is likely an underestimate since teams may use the tool at any time it may benefit planning. SIT continues to work with and explore accurate data collection in collaboration with LITs and the Act 264 Board.

Figure 2: Number of Coordinated Services Plans Reported by Region (Estimated)

REGION	2015	2016	2017	2018	2019
Barre	60	50	60–80	75	80–90*
Bennington	★	★	25–30	25	30–40*
Brattleboro	40	40	40	75	45
Burlington	150–200	83	180	227	134
Hartford	★	★	75-80*	★	87
Middlebury	★	★	60	63	67
Morrisville	50	40–60	50–60*	50–70*	62
Newport	★	★	17	45	26
Rutland	★	66	70	60	★
Springfield	38	29	28	28	46
St. Albans	★	100	100	125	150
St. Johnsbury	★	★	11	15	19
TOTALS*	338	408	716	728	746

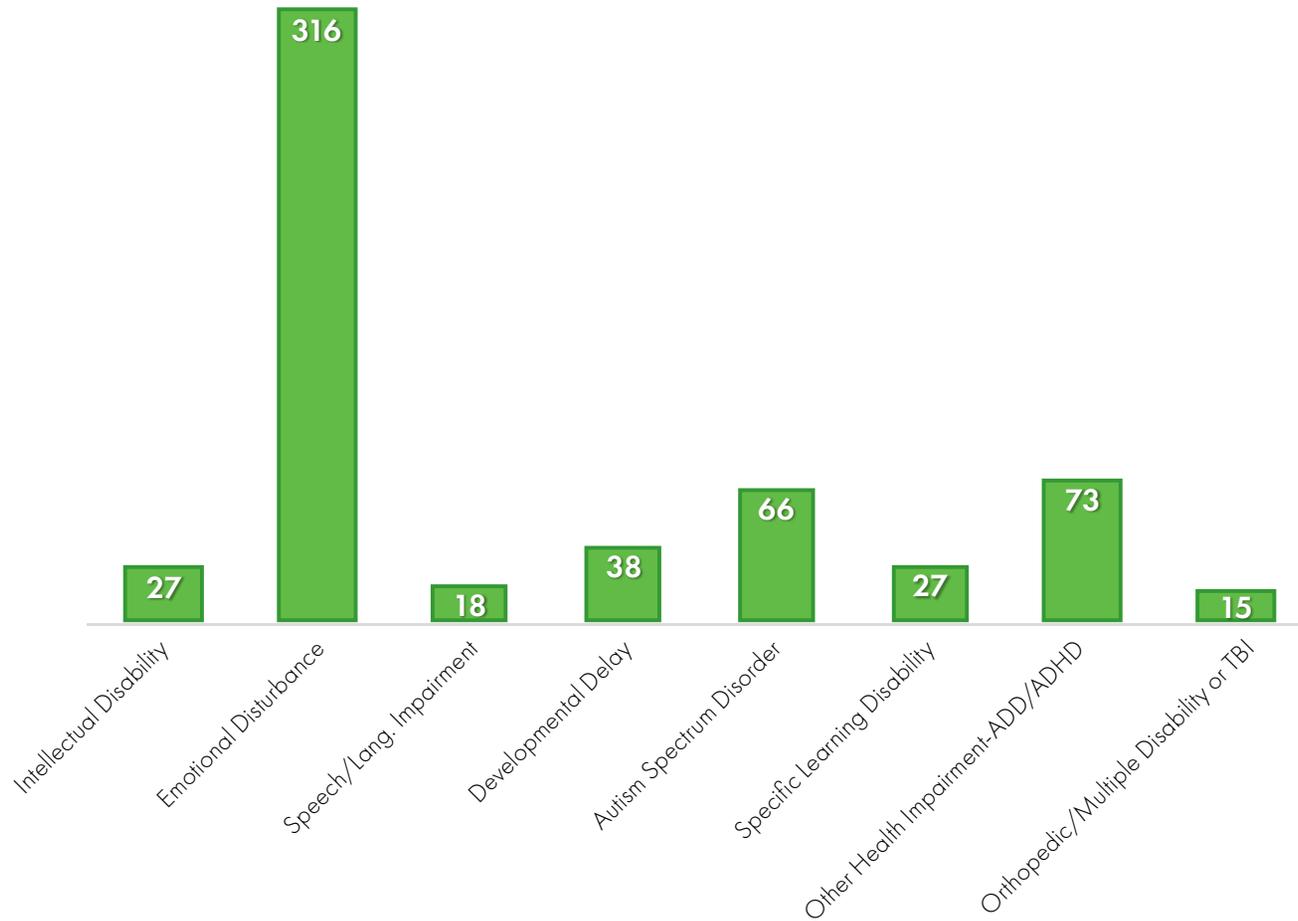
* When a range was identified, the lower end was utilized for this calculation

★ Data not reported

★ Special Note: Due to the COVID pandemic, CSP data for 2020 will be reported in next year’s report.

Through the Agency of Education’s Special Education Child Count data⁷, there is data identifying children/youth who had a CSP and are receiving special education services. The data is unduplicated children; the primary disability is identified; secondary and tertiary disabilities are

not included. It is important to note that not all students who access a CSP are eligible for special education. Some students have 504 Plans or Educational Support Team (EST) Plans.



580 Students Total

- 15 in Kindergarten
- Less than 11 Early Childhood Special Education
- 195 in grades 1 through 6
- 99 in grades 7 and 8
- 263 in grades 9 through 12+

Males = 419 (72%)
 Females = 161 (28%)

⁷ Child Count Data for children ages 3-21 as of December 1, 2018

In Fiscal Year (FY) 2019, Vermont’s Designated and Special Services Agencies (DA/SSA) child, youth and family mental health programs served 10,218 children and youth.⁸

Figure 3: Children’s Mental Health Services

FY19	# of Children Served	Ages 0-6	Ages 7-12	Ages 13-19	Ages 20-34	Male	Female
Overall	10,218	18%	38%	41%	41%	56%	44%
Services Received through DA/SSA			FY15	FY16	# Children FY17	FY18	FY19
Therapies			4,349	4,003	3,839	3,812	3,675
Medication and consultation			1,257	1,344	1,337	1,352	1,195
Clinical interventions			6,523	6,322	6,291	6,688	6,241
Service Planning and Coordination			7,343	7,531	7,138	7,491	6,780
Community Supports			8,685	8,493	8,333	8,344	8,020
Crisis assessment, supports, and referrals			1,965	1,558	1,170	1,277	1,137
Respite			445	302	215	192	180

The Vermont DMH conducts annual perception of care surveys to monitor DA/SSA program performance from the perspective of service recipients and other stakeholders, alternating years to survey parents and youth. The most current available data (2017) from parents showed that

82% of parents of children served by child and adolescent DA/SSA mental health programs in Vermont rated the programs favorably. In addition, 81% of the surveyed youth (2018) evaluated the programs positively on the Overall measure of program performance.

⁸ DMH FY2019 Statistical Report

COVID-19 Specific Activities within DMH

In the midst of the public health emergency, Vermont's mental health system also needed to navigate new state and federal policies while providers continued to offer treatment and resources to communities. The north star DMH looks to is ensuring quality care and access to services for Vermonters. In fact, Vermont ranks first in the nation for access to mental health services, according to the annual [State of Mental Health](#)

[in America report](#). The State of Mental Health in America report includes national and state data from all 50 states and the District of Columbia. State rankings reflect both adult and youth (age 12-17) data and are based on 15 mental health and access measures, including the prevalence of mental illness, substance use disorders and access to mental health services.

DMH also focused energy on many initiatives during the pandemic. Some of these include:

► **Telehealth Services:**

- A majority of clinical and case management services are now provided via phone and telehealth. Mental health screeners are conducting confidential assessments via telehealth for Vermonters in crisis who are at their homes or in Emergency Departments.
- Staff at mental health agencies have reported that many families prefer telehealth opportunities as it decreases transportation challenges, increases ease of connecting with others and offers flexibility they didn't have prior to COVID.
- DMH submitted and received a grant from The Vermont Community Foundation to supplement the DA/SSA network funds for technology purchases for clients to support telehealth. Various federal grants will assist with technology for staff at DA/SSAs but there was no funding available for client technology needs. This grant of \$100,000 was provided directly to the network as unrestricted funds.

► **In-person supports:**

- For some clients who may not have access to remote services or those who need direct support, agency staff are providing face-to-face care including mental health crisis assessments, emergency examinations, and support services that are deemed essential. Agencies have been creative about how to safely see children and youth including putting up outdoor tents over the summer, using large indoor spaces as available, and meeting in parks and other recreation areas.

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► **Fiscal Stability:**

- DMH was able to maximize the flexibility of the current Mental Health Case Rate model of which DA/SSA providers are paid monthly for case rate services on a prospective basis using an annual budget and adjusting the reconciliation process to reflect changes in practice and utilization due to Covid-19. This helped ensure fiscal stability of mental health agencies during this challenging time.
- Expedited payments to mental health agencies for Electronic Health Record (EHR) implementation.
- Adjusted minimum thresholds for Success Beyond Six services.

► **Resources:**

- The Department of Mental Health applied for and was awarded a grant from the Federal Emergency Management Agency (FEMA) that is focusing on advancing both public health and mental health information and messaging to support populations immediately impacted by Covid-19. [COVIDSupportVT](#) was established in partnership with Vermont Care Partners to undertake this work.
- The Department of Mental Health also created [several webpages](#) specific to supports for individuals, providers and community members to offer guidance on self-care, how to access supports, managing isolation, and parenting during a pandemic.



The Vermont Developmental Disabilities Act (DD Act) in 1996 required that the Developmental Disabilities Services Division (DDSD) adopt a plan to provide services to Vermonters with developmental disabilities. DDSD was required to develop a System of Care Plan which would outline eligibility, services, and funding priorities for Vermonters with Developmental Disabilities across the lifespan.

A developmental disability is defined as having a diagnosis of intellectual disability OR an Autism Spectrum Disorder, AND significant deficits in adaptive functioning, AND onset of the disability prior to age 18. The primary funding mechanism for services through the DDSD is the Home and Community Based Services (HCBS) individualized budget (formerly known as a DS waiver). Depending on the needs of a child/youth, services may include service coordination, home supports, respite, clinical, crisis, and/or accessible transportation. HCBS are provided through the state's not-for-profit DAs and SSAs. There are also options for individuals and families to self or family-manage their services.

- Family Managed Respite is funding for families of children/youth who have a MH and/or ID/DD diagnosis
- Flexible Family Funding is available to eligible children with a developmental disability (DD). These funds may be used for respite or goods that enable the individual to continue living successfully with their family.
- Bridge Case Management—care coordination for children with developmental disabilities

In Franklin/Grand Isle and Addison counties, services to children, regardless of disability type, are provided through an integrated approach and case rate. In addition, the Howard Center has developed a unique

To receive HCBS, an individual must have a developmental disability, be a Vermont Medicaid recipient, and meet a funding priority outlined in the DDSD System of Care Plan. There are two funding priorities for children/youth under the age of 18, limiting HCBS to those with the most intensive needs. These priorities are Preventing Institutionalization—Nursing Facilities and Preventing Institutionalization—Psychiatric Hospitals and Intermediate Care Facilities (ICF/DD).

Additionally, through an inter-departmental Memorandum of Understanding, children with developmental disabilities who are in DCF custody may receive HCBS services if requested by DCF without the requirement to meet a funding priority. At the time of this report, 11 children with developmental disabilities who are in DCF custody receive HCBS.

For children and youth with developmental disabilities who do not meet a funding priority in the DDSD System of Care Plan, other supports and services may be available to them.

program, also using a case rate with funds included from DAIL and DMH, called ARCh (Accessing Resources for Children) which provides service coordination, skills work and clinical support to 315 children/youth in FY20.



Figure 4: Developmental Disabilities Services Data

The data in this figure was produced by DAIL-DDSD

Program	Number of Children/Youth Served				
	FY2015	FY2016	FY2017	FY2018	FY2019
Home and Community-Based Services (Ages 0-18)	64	62	58	65	63
Home and Community-Based Services (Ages 18-22)	194	216	221	219	210
BRIDGE program: Care Coordination (Ages 0-22)	300	323	391	391	395
Flexible Family Funding (Ages 0-18)	750	725	729	742	735
Flexible Family Funding (Ages 18-22)	201	220	211	220	216
Family Managed Respite (FMR) (Statewide allocation to children /families. Note: More FMR was allocated—this data only includes how many used it)	323: <ul style="list-style-type: none"> • 165 ID/ASD diagnosis • 123 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis 	384: <ul style="list-style-type: none"> • 197 ID/ASD diagnosis • 146 MH diagnosis • 41 co-occurring ID/ASD and MH diagnosis 	523: <ul style="list-style-type: none"> • 256 ID/ASD diagnosis • 226 MH diagnosis • 41 co-occurring ID/ASD and MH diagnosis 	416: <ul style="list-style-type: none"> • 200 ID/ASD • 181 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis 	441: <ul style="list-style-type: none"> • 240 ID/ASD • 166 MH diagnosis • 35 co-occurring ID/ASD and MH diagnosis
Vermont Crisis Intervention Network	<ul style="list-style-type: none"> • 95 total bed days were children, or 18% • 7 individuals were children, or 20% 	<ul style="list-style-type: none"> • 74 total bed days were children, or 12% • 4 individuals were children, or 9.5% 	<ul style="list-style-type: none"> • 91 total bed days were children, or 15.6% • 5 individuals were children, or 15.6% 	<ul style="list-style-type: none"> • 115 total bed days were children, or 18.8% • 5 individuals were children, or 12.8% 	<ul style="list-style-type: none"> • 121 total bed days were children, or 22.16% • 4 individuals were children, or 10%

Post-Secondary Education Initiative

This initiative partners with several direct support programs which help young adults acquire two-year college certificates and degrees. SUCCEED, Think College Vermont, and College Steps work closely with DA and SSAs to help youth access careers and increase independent living skills via campus based post-secondary education. For over eleven years, this initiative has demonstrated that youth with developmental disabilities can not only handle college but can excel in their coursework and extracurricular interests.

Each program matches students with internships based on the students' strengths, contributing to high employment outcomes at graduation. Northern Vermont University at Johnson and Lyndon, Castleton University, American International College and University of Vermont (UVM) participate in this initiative.

Of the forty-two students who graduated in 2019, 86% were employed

at graduation. Thirty-four students remained enrolled and 44% of these students were employed while going to school. The model promotes success via full campus inclusion and customized academic support.

During the spring and fall semesters of 2020, the COVID pandemic forced students into a remote/distance model of learning and campus activities were suspended. The post-secondary programs worked to ensure students received the same levels of mentor support they had on campus by connecting them with their mentors virtually. In addition to traditional academic supports provided by mentors, ways of connecting included blogging, Facebook, mentor/student Zoom meetings, and group meetings to bring people together. Offerings such as Zoom Yoga, Pilates, book discussions, and other recreational meet ups have helped to ease some of the hardship of not being on campus.

COVID-19 Specific Activities within DAIL/DDSD

As with other departments within AHS, the onset of the COVID-19 pandemic in the early months of 2020 required DAIL/DDSD to regroup and refocus as a system of care and adapt support and funding mechanisms to ensure appropriate service delivery to Vermonters with

developmental disabilities. In addition to the pandemic-specific activities DDSD rolled out, our system faced challenges during this time and discovered promising practices our system may look to continue beyond the pandemic. Some of these initiatives include:

- **COVID-19 Emergency Supports for Unpaid Family Caregivers:** Developmental Disabilities Home & Community Based Services – Conversion of Respite and/or other Family-Managed Funds to Difficulty of Care stipends to maintain the health and safety of a minor or adult child for the duration of the COVID-19 state of emergency.
- **Home & Community Based Services:** Flexible COVID-19 Crisis Stipend to Parents (FY 2020). Additional monies available from the Coronavirus Relief Fund to offer a one-time crisis stipend to parents residing with and providing care to their minor or adult child who cannot access typical hourly or daily supports due to the COVID 19 state of emergency.
- **Family Managed Respite:** Non-Home & Community Based Services Allocation Increase to Designated Agencies for COVID-19 State of Emergency (during final quarter of FY 2020). Additional Family Managed Respite (FMR) funds made available to parents of children/youth under age 21, whose children reside with them, and who do not have approved HCBS budgets/services.

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- ▶ **Flexible use of One-Time Funds allocation to DAs and SSAs:** One-time funds may be used to address health and safety and/or crisis needs of any individuals within the Designated Agency catchment areas and current recipients at SSAs who are eligible for services. Many providers utilized one-time funds to assist individuals to access technology.
- ▶ **COVID-19 State of emergency increased funding and flexibility for Shared Living Providers:** Additional DAIL funds to augment Difficulty of Care stipends for Shared Living Providers (SLPs), and other policy flexibilities for SLPs.

Guidance Documents in the following areas:

- Office of Public Guardian
- Personal Protective Equipment (PPE) Availability
- In-Person Services—guidance for health and safety protections
- Assessment tools for COVID-19 return to community activities and employment
- COVID-19 Guidance for Providers of DD Services—service delivery, funding and administrative flexibilities as have evolved over time
- Town Halls in partnership with VFN and GMSA

Challenges during the pandemic:

- Workforce and capacity issues
- Challenges related to not having in-home supports
- Pressures on families to supervise remote education services as well as attend to other family and work responsibilities
- Increase in the acuity of needs for children and youth with dual diagnosis and accessing the expertise to meet their developmental and mental health needs
- The promising potential of an integrated Mobile Response pilot could not be actualized
- Increased number of individuals graduating early due to a lack of school services

Innovations and practices to preserve beyond the pandemic:

- Remote service provision such as case management/service coordination if it meets individual needs
- Virtual team meetings enabling easier access for participation and bringing all voices to the table
- Town Halls and listening sessions to engage stakeholders for information-sharing and feedback, successful collaborations for these events with Green Mountain Self Advocates and Vermont Family Network

The Social Security Act requires state Medicaid programs to provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services to all Medicaid eligible individuals under age 21, which includes ABA services. The ABA Case Rate payment reform initiative came in response to providers' feedback that the administrative components of ABA, namely the prior authorization process and the complexity of the billing codes, interfered with their ability to deliver services to clients. This in turn, impacted the number of members actively enrolled in the ABA benefit.

After extensive planning and design work, Vermont Medicaid transitioned from traditional fee-for-service reimbursement to a single-factored tiered rate on July 1, 2019. As a result of this reform, providers are no longer required to complete prior authorization requests, nor must they wait for approvals of changes to treatment plans. The tiered rate

- What the provider should have received in tier payments, given the actual amount of services provided for each month from July 1, 2019 through December 31, 2019, and
- What each ABA provider was actually paid in tier payments and tiered hours billed and paid as fee-for-service payments for each month from July 1, 2019 through December 31, 2019.

VT Medicaid is aware this is a very difficult time for many providers due to the COVID-19 pandemic and the resulting decline in treatment service hours. As a result, VT Medicaid is making every effort to provide

- 1 VT Medicaid provided flexibility in the claim's submission deadline for this initial reconciliation; the reconciliation will be based on the complete data set as of June 30, 2020 rather than the original date of March 31, 2020.
- 2 VT Medicaid worked with providers to support access to services and maintain provider capacity and explored alternate ways of meeting members' needs. The expansion of service delivery by telemedicine and audio phone only and Vermont Medicaid's Sustained Monthly Retainer Payments program are examples of those efforts.
- 3 To further support providers, VT Medicaid will offer flexible repayment options for providers that owe money to allow them to tailor the repayment schedule to meet their specific needs. Providers will be given flexibility regarding the start date of repayments, the weekly amount to be recouped, and the duration of recoupment (the recoupment timeframe may be extended beyond 12 months if needed).

COVID-19 Specific Activities within DVHA

VT Medicaid responded quickly to treatment delivery issues that resulted from the COVID-19 pandemic by expanding the number of ABA codes authorized for telemedicine. This increased available treatment

allows providers to determine the appropriate treatment and to adjust and respond immediately to changes in their members' medically necessary service needs. Some restrictions placed on codes when delivering ABA services have been lifted, allowing providers more flexibility in the delivery of services. Data shows an increase in not only the number of enrolled members but also the number of ABA clinicians enrolled as VT Medicaid providers since the benefit became effective in 2015. DVHA will continue to perform quality improvement check-ins to ensure the benefit is running smoothly so enrollment continues to increase over time.

VT Medicaid is working with providers to complete the 2019 reconciliation which includes dates of service from July 1st, 2019 through December 31st, 2019. To determine reconciliation results, VT Medicaid calculated the difference (for each provider and member) between:

flexibility to those providers with a debt to VT Medicaid as a result of this reconciliation. These initiatives include:

opportunities for providers who would have otherwise been unable to continue necessary treatment. DVHA will continue to work with providers to ensure members receive ABA treatment whenever clinically indicated.

Children with Special Health Needs (CSHN) supports Vermont children and youth by ensuring comprehensive, culturally sensitive, community-based, and family-centered services. This is a free public health program for families, partially funded by the Title V block grant secured through the Maternal Child Health Bureau and Medicaid.

CSHN supports children with complex, chronic health conditions and/or developmental disorders, ages birth to 21, with flexible and proactive

services. Supports are provided by a team of medical social workers, nurses, and other specialty providers, experienced and skilled in working with children, families, and providers.

While the needs of a child are often what prompts a referral to CSHN, our multidisciplinary team takes a holistic, family-centered approach. There are a variety of services and programs available depending on the needs of the child and family, including:

- Care Coordination
- Children's Personal Care Services
- Pediatric Hi-Tech Nursing
- Pediatric Palliative Care
- Child Development Clinic
- Community Nutrition Services
- Newborn Screening

More specifically, CSHN focuses on the following, which we know can be particularly challenging for children and families.

- Navigate the healthcare system
- Provide respite funding for parents and caregivers who need a break
- Coordinate care conferences with the various providers caring for a child
- Collaborate with schools and special educators to create meaningful and appropriate educational plans
- Access health insurance, medical care, and services
- Identify services and resources that may be helpful for a child and family
- Assist with transitions from services throughout a child's life
- Plan and prepare for adulthood
- Meet children and families in a setting that is most comfortable for them

To effectively address these needs, CSHN regional social workers are integrated with their local Children's Integrated Services, Building Bright Futures, Local Interagency Teams, and Transition (through VocRehab) teams.

2020 Updates

CSHN provides care coordination and/or consultation to approximately 700 individual families per year, as well as countless community providers and partners. In 2020, this included over 200 families new to CSHN. Nearly 1,500 children are enrolled in the three Vermont Medicaid programs we administer—Children’s Personal Care Services, Pediatric Palliative Care Services, and Pediatric High-Tech Nursing—and approximately \$76,000 in respite funds were awarded to families in FY 2020.

In continuation of the ongoing efforts to improve the delivery of High-Tech Nursing services, CSHN is engaged in a payment reform project, led by the Department of Vermont Health Access (DVHA), in collaboration with the Department for Disabilities, Aging, and Independent Living (DAIL). This work seeks to increase service delivery by developing and implementing a payment model that provides fiscal stability and predictability for High-Tech Nursing provider agencies. Various community partners and stakeholders have informed this work as well.

CSHN staff assisted in the development of a new High-Tech Nursing policy that allows parents and caregivers who are registered nurses to enroll as independent Vermont Medicaid providers, in order to be

COVID-19 Specific Activities within CSHN

As with all aspects of the system of care in Vermont, CSHN has been significantly impacted by the COVID-19 public health emergency—and this impact is ongoing. Since March, all CSHN staff have, at times, been reassigned to assist with the Vermont Department of Health’s COVID response. CSHN medical social workers, administrative staff, and clinical/nursing staff have contributed to contact tracing efforts, call center work, and as key resources for school administrators and nurses. In certain cases, CSHN staff have assumed crucial leadership roles, assisted with on-the-fly process improvement, and participated in special project teams tasked with identifying vulnerable populations who require culturally sensitive and developmentally appropriate COVID resources.

At the start of the pandemic, CSHN identified the essential functions of its Medicaid programs necessary to ensure continued operations during staff

compensated for providing nursing care to their high-tech eligible child or family member.

Similarly, CSHN Community Nutrition Services transitioned to a model that allows registered dietitians to bill insurers, including Vermont Medicaid, directly. This aligns more closely with the intended usage of Title V block grant funds, while maintaining a network of expertly trained dietitians to meet the nutritional and dietetic needs of children and youth with a variety of diagnoses.

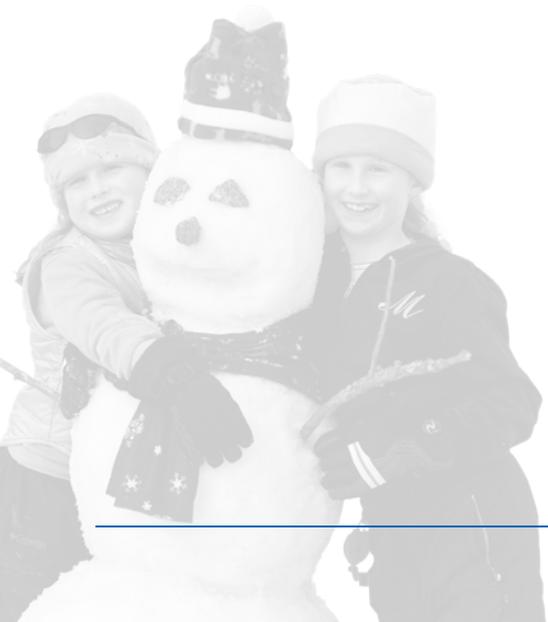
Near the end of 2019, representatives from CSHN joined with colleagues across the Division of Maternal-Child Health (MCH) at the Vermont Department of Health to form the Family Partnerships Steering Committee. This group aims to build and sustain a culture of family engagement throughout the division, based in an understanding that it is best practice for families to be involved in all aspects of programmatic improvement, including advisory committees, development of educational materials, service delivery models, and policy-making. The initial output of this work is a toolkit intended to streamline and standardize the process for onboarding family partners into CSHN and MCH projects.

reassignments. These include continuing with eligibility reviews, internal and external referrals, service authorizations, and child-specific consultation.

For example, CSHN partnered with DAIL and DVHA to draft and implement policy changes related to Children’s Personal Care Services (CPCS) that enable parents and caregivers of eligible children to access CPCS funds themselves. Rather than risk exposure to the coronavirus by receiving supports from an external PCA provider, [CPCS COVID payments](#) are made directly to parents and caregivers, who are otherwise prohibited from being paid, under longstanding federal Medicaid rules. Of the almost 1000 children actively enrolled with the fiscal agent that provides payroll services to CPCS families, over 600 individual caregivers have been paid for the extra personal care they are providing during the public health emergency.

In November 2020, VFFCMH requested the Act 264 Board consider one of their 2021 System of Care recommendations be a comprehensive review of the role of Local Interagency Team Parent Representatives (LIT PR) and the infrastructure necessary to recruit, train, compensate and retain those serving AHS regions statewide. The pandemic and transition to virtual meetings has made it possible for the State Parent Rep and LIT

PRs statewide to temporarily serve communities where LIT PR vacancies currently exist. A 2021 review will help facilitate dialogue to explore opportunities as we look forward to a return to in-person meetings and an increase in the number of children served under the vision of Act 264 in the Coordinated Services Planning process.



In 2019, a Coordinated Services Plan (CSP) meeting was called to support a family whose child has autism and co-occurring diagnoses—one of two children in the family with special needs. The family was receiving support from the designated agency and an alternative school placement. The family and service providers had been able to meet the child's needs, but as the child was growing and the needs were intensifying, both family and community supports were struggling.

- The team tried to coordinate providers for both children so the family could have a few hours of coordinated respite
- The team met the family where they were, and offered information about future supports
- The team sought creative ways to leverage the current team and maximize service to supports during the pandemic
- The designated agency helped the family understand and navigate residential placement with the goal of reunification back home and in the community
- The team was empathic and transparent about long-term services and how difficult these decisions are for the family
- Vermont Family Network support offered preparation for the CSP, organization tools, peer match, and educational support in the IEP meeting

The outcome was a fine-tuned care plan, with coordination, communication, an offer of peer support, safety planning, and options for

A CSP meeting convened in 2020 and the team revisited the current schedule of care providers, school navigation, and offered Individual Education Program (IEP) support and as well as guidance in exploring residential treatment facilities. While waiting for residential placement, COVID-19 impacted the availability of in-home providers, leading the team to seek creative ways to leverage current support. For example:

more intensive treatment and long-term planning. And the team remained open to exploring intensive residential treatment if the family requested it.

A statutory requirement of the Act 264 Board is to advise the Agency of Education and Agency of Human Services (AHS) on the annual priorities for developing the System of Care.

The following recommendations were submitted to SIT in November 2020.

1. Act 264 requires the state to ensure that there is a Parent Representative on every Local Interagency Team and that families have knowledge of and access to Parent Representatives' services.
 - a. [The Act 264 Board and SIT will collaborate during 2021](#) to review how we might improve the process of recruiting, training, funding, and supporting Parent Representatives. They will produce a document by October 1, 2021 which lists possible improvements and any recommendations they may have.
 - b. [Provide easily accessible links to Act 264's Coordinated Service Plans \(CSPs\)](#) on the websites of the Department for Children and Families (DCF), the Department of Health (VDH), and the Department of Corrections (DOC).
2. Retain and integrate effective innovations emerging from addressing the needs of our community during a global pandemic.
 - a. [Ensure that billing for telehealth remains an option.](#) Virtual meetings and telehealth offer ease of connection for professionals and increase the ability of families to participate by reducing time and money spent on traveling.
 - b. [Develop and implement a statewide solution to consistent and reliable internet connectivity](#) and technology accessibility to ensure that essential services and remote education can be provided to all Vermont families and businesses.
3. Demonstrate a strong commitment to develop and implement an integrated approach for child and family programs and services across the state.
 - a. Support the efforts of [Building Flourishing Communities](#) and statewide coordination across agencies with a focus on [resiliency](#) and [trauma-informed services](#).
 - b. Support healthcare payment reform efforts away from 'fee for service' payment frameworks and towards [accountability funding based on program performance measures and client outcomes](#).

(Continued on page 22)



Appendix A: Act 264 Statutory Language

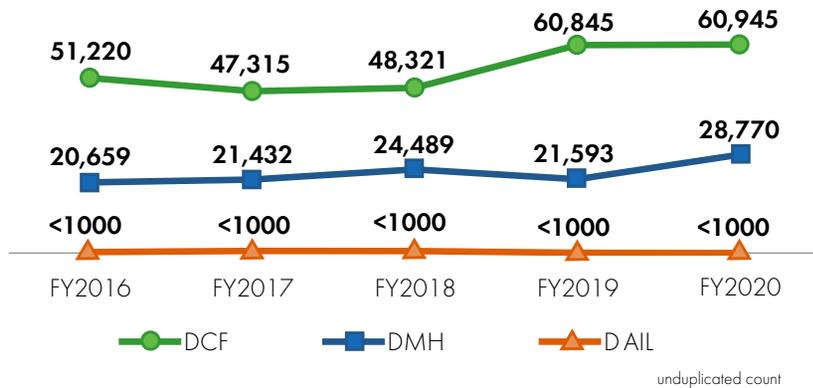
Per 33 VSA § 4302: The State Interagency Team shall have the following powers and duties:

1. Submit an annual report to the commissioners of developmental and mental health services, social and rehabilitation services and education on the status of programs for children and adolescents with a severe emotional disturbance which shall include a system of care plan. The system of care plan shall identify the characteristics and number of children and adolescents with a severe emotional disturbance in need of services, describe the educational, residential, mental health or other services needed, describe the programs and resources currently available, recommend a plan to meet the needs of such children and adolescents, and recommend priorities for the continuation or development of programs and resources.
2. Develop and coordinate the provision of services to children and adolescents with a severe emotional disturbance.
3. Make recommendations to the local interagency team for resolution of any case of a child or adolescent with a severe emotional disturbance referred by a local interagency team under subsection 4303(f) of this chapter.
4. Recommend to the Secretaries of Human Services and of Education and the Commissioners of Mental Health and for Children and Families any fiscal, policy, or programmatic change at the local, regional, or State level necessary to enhance the State's system of care for children and adolescents with a severe emotional disturbance and their families. (Added 1987, No. 264 (Adj. Sess.), § 2; amended 1989, No. 187 (Adj. Sess.), § 5; 1995, No. 174 (Adj. Sess.), § 3; 2013, No. 92 (Adj. Sess.), § 295, eff. Feb. 14, 2014; 2013, No. 131 (Adj. Sess.), § 69, eff. May 20, 2014.)

Appendix B: Children and Youth in Residential Care: Bed Days and Total Child Count

Data source: Department of Mental Health

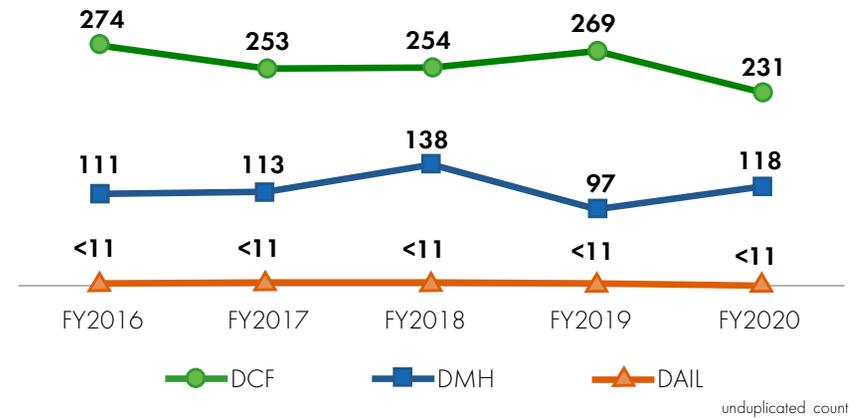
Total Residential Bed Days by Department per Fiscal Year Through FY20 Q4



Total Bed Days

Total Bed Days is the total number of days a child/youth stays overnight in a residential program. For the Total Bed Days chart, children who were placed in more than one program during the fiscal year are represented more than once so that all bed days are calculated.

Total Child Count Residential by Department per Fiscal Year Through FY20 Q4



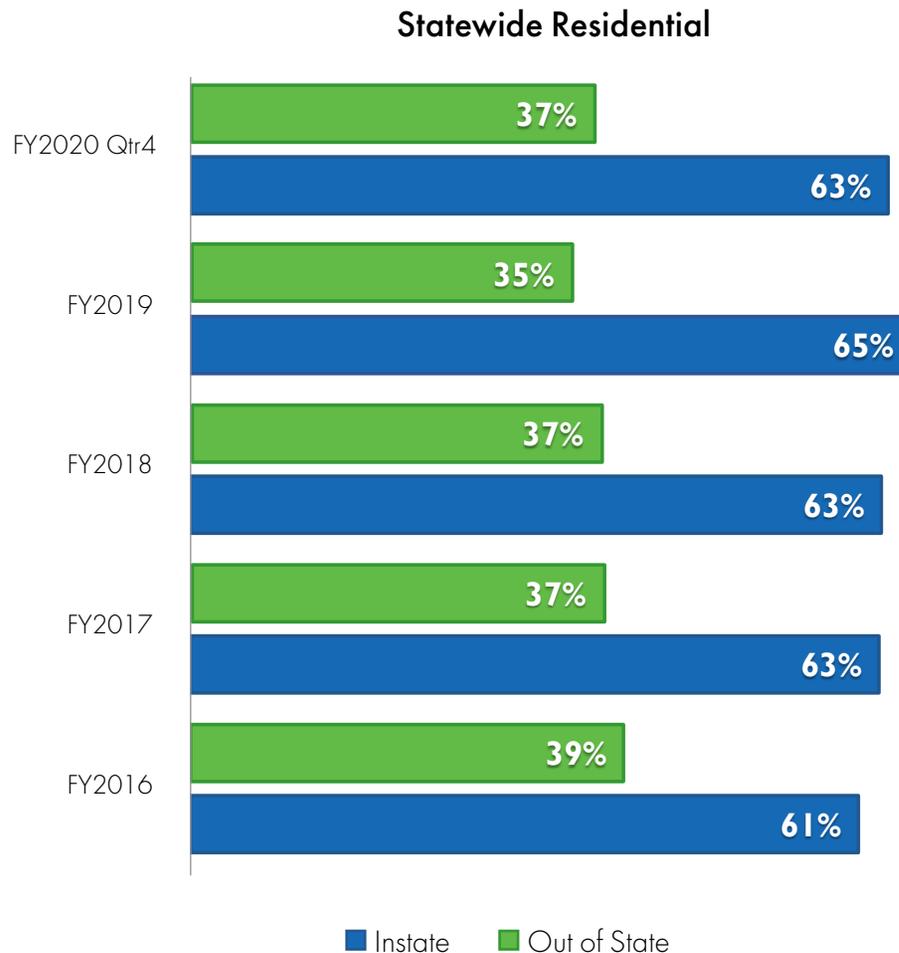
Total Child

For the Total Child Count in Residential by State fiscal year, the number of children/youth is unduplicated within the fiscal year, meaning if a child/youth was placed in more than one residential program during the fiscal year, the child/youth is only counted once.

Appendix C: Children and Youth in Residential Care: In-State and Out-of-State

Data source: Department of Mental Health

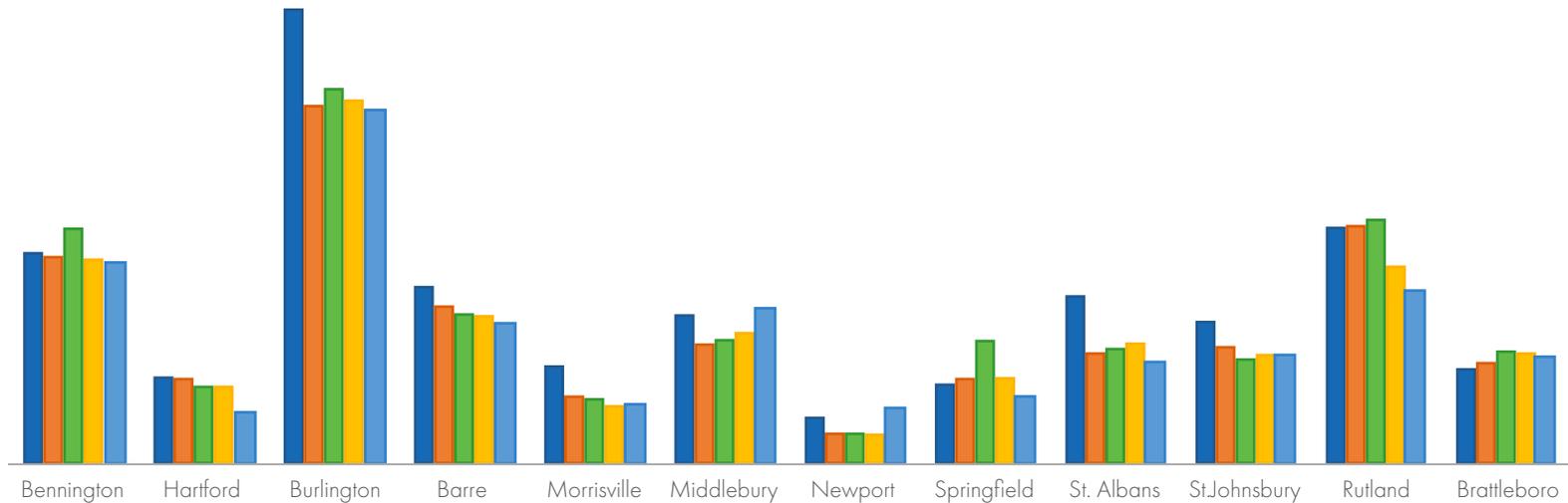
The following chart represent the breakdown of in-state placements compared to out-of-state placements. If a child was placed in more than one program in a fiscal year, they are represented more than once.



Appendix D: CIS Specialized Child Care Caseloads Data from FY2014 through FY2020

Data source: DCF-Child Development Division

Specialized Child Care provides vulnerable children and high-risk families with quality childcare and specific supports that help meet their needs, strengthen their families, and promote their children's development.

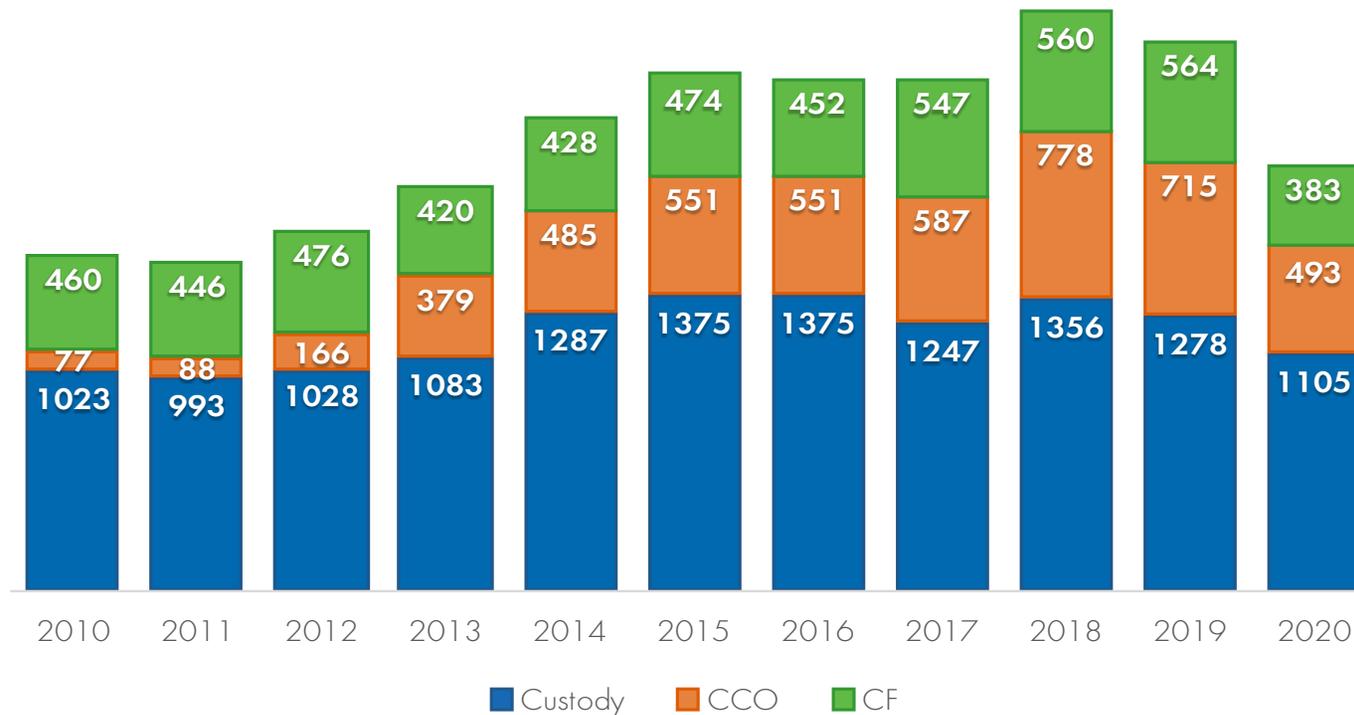


	Bennington	Hartford	Burlington	Barre	Morrisville	Middlebury	Newport	Springfield	St. Albans	St. Johnsbury	Rutland	Brattleboro
SFY2016	240.5	99.5	516	202	112	170	54	91.5	191.5	162.5	269	109
SFY2017	236	98	407	180	78	137	36	98	127	134	271	116
SFY2018	268	89	426	171	75	142	36	141	132	120	278	129
SFY2019	233	89	413	169	67	150	35	99	138	125	225	127
SFY2020	228	58	401	159	67	176	63	76	115	123	196	121

*The statewide Child Care Financial Assistance Caseload average is determined by using the Bright Futures Information System Subsidy Case Extract. The data is pulled each month, cases closed in the month are excluded, and the data is unduplicated by case ID. This data represents cases that were open at the end of the month and had an active authorization. Each month's data is then averaged by case manager, and then compiled at the district and statewide level.

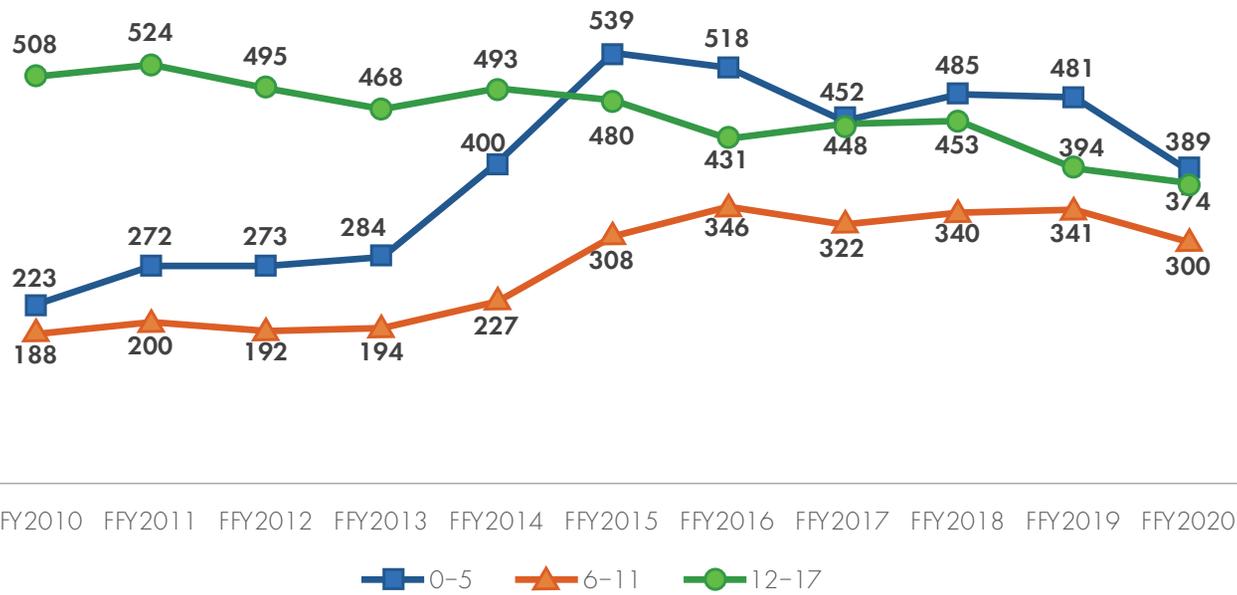
Appendix E: Children/Youth involved with DCF Custody, Conditional Custody Order (CCO) and Family Support Cases (CF)

Data source: FSD Quarterly Management Reports (2010-2020)-last day of Q2; FSD Report Catalog Full Caseload Report and CCO report for non-custody. Data note: non-custody case type reports are point-in-time and may not be reflective of the last day of Q2 each year.



Appendix F: Number of Children/Youth in DCF Custody by Age Group

Data Source: FSD Quarterly Management Reports-last day of Q3.



Appendix G: References

Act 264 Statutory Reference: <http://legislature.vermont.gov/statutes/section/33/043/04302>

Act 264 Information and materials: <http://ifs.vermont.gov/docs/sit>

Agency of Education, Act 46 Report: <http://education.vermont.gov/documents/legislative-report-act46-sec46-special-education-funding>

Agency of Education, Special Education Website: <https://education.vermont.gov/student-support/special-education>

DAIL System of Care Plan for DS Services FY18-20: <http://dail.vermont.gov/draft-care-plan-DS-services-FY18-20>

DCF-Family Services Performance Measures Dashboard: <http://dcf.vermont.gov/scorecard>

DCF-Family Services, 2019 Report on Child Protection in Vermont: <https://dcf.vermont.gov/sites/dcf/files/Protection/docs/2019-CP-Report.pdf>

Developmental Disabilities Services State Fiscal Year 2019 Annual Report: https://ddsd.vermont.gov/sites/ddsd/files/documents/DAIL_DDS_Annual_Report.pdf

DMH Stats Report, FY2019: https://mentalhealth.vermont.gov/sites/mhnew/files/documents/Reports/Stats/DMH-2019_Statistical_Report.pdf

Vermont Family Network: <http://www.vermontfamilynetwork.org/>

Vermont Federation of Families for Children's Mental Health: <http://www.vffcmh.org/>

Youth Risk Behavior Survey Report, 2019: https://www.healthvermont.gov/sites/default/files/documents/pdf/HSVR_YRBS_2019_HSReport.pdf

